



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE FORT WORTH

Respondent Name

INDEMNITY INSURANCE CO

MFDR Tracking Number

M4-14-0849--01

Carrier's Austin Representative

BOX NUMBER: 15

MFDR Date Received

NOVEMBER 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was sent in and denied for duplicate claim. This is the patient's initial evaluation. Our office never received EOB from first submission and reconsideration was done."

Amount in Dispute: \$385.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 25, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2012	CPT Code 99204 CPT Code 99080	\$269.09	\$15.00
November 27, 2012	CPT Code 97001	\$116.71	\$116.71

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or

- after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
 3. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for Work Status Reports

The services in dispute were reduced/denied by the respondent with the following reason codes:

- 18 – Exact duplicate claim/service.
- 476 - \$385.00 of the charges are duplicates of bill # 888-H-15359569-01..

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §129.5?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Detailed History
 - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed one chronic condition, lumbar spine, thus, this component was not met.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed one system, musculoskeletal, this component was not met.
 - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. The documentation did not list any past family or social history. This component was not met.
- Documentation of a Detailed Examination:
 - Requires extended exam of affected area(s) and other symptomatic or related organ system(s), additional systems up to total of seven systems to be documented. The documentation found listed one body area/organ system, lumbar spine. This component was not met.

The requestor also billed a Work Status Report in conjunction with the initial office visit. In accordance with 28 Texas Administrative Code §129.5, (d)(1) The doctor shall file the Work Status Report after the initial examination of the employee, regardless of the employee's work status; and (i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section. Review requestors documentation finds sufficient documentation to

support reimbursement; therefore, reimbursement in the amount of \$15.00 is recommended.

On November 27, 2012 the requestor billed CPT Code 97001, defined as a Physical therapy evaluation: The health care provider examines the patient/client, which includes a comprehensive history, systems review, and tests and measures. Tests and measures may include, but are not limited to, range of motion, motor function, muscle performance, joint integrity, neuromuscular status, and review of orthotic or prosthetic devices. The provider formulates an assessment, prognosis, and notes an anticipated intervention. Review of the physical therapy evaluation finds that the requestor provided sufficient documentation to support reimbursement. Therefore, reimbursement in the amount of \$116.71 $((54.86 \div 34.0376) \times \$72.57)$ is recommended.

2. For the reasons stated above, the division concludes that the documentation sufficiently supports reimbursement for some services.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for CPT Codes 99080-73 and 97001. As a result, the amount ordered is \$131.71.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$131.71 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 31, 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.